DOCUMENT RESUME

ED 040 428 CG 005 432

AUTHOR	Lourie, Norman; Walden, Daniel
TITLE	The Lessons of Historical Reform Movements: The Racism Mental Health Equation.
INSTITUTION	American Orthopsychiatric Association, New York, N.Y.
PUB DATE	25 Mar 70
NOTE	21p.; Paper presented at the American Orthopsychiatric Association Convention, San Francisco, California, March 23-26, 1970
EDRS PRICE	EDRS Price MF-$0.25 HC-$1.15
DESCRIPTORS	Community, Community Health, *Community Health Services, Community Problems, Community Programs, Community Services, *Economically Disadvantaged, *Mental Health, Mental Health Programs, *Racism, Social Action, *Social Change, Social Problems, Social Responsibility, Social Services, Welfare, Welfare Agencies, Welfare Services

ABSTRACT

The history of reform and the origins of unrest in America are briefly reviewed. Concurrent reform streams of the past are examined in terms of an emerging awareness of the relationship between racism and poverty and social environment. The mental health and social welfare movements paralleled this recognition, but did not lead the new reform. There were no fundamental changes in practice until the civil rights revolution shocked them into awareness. Recently, these groups have viewed poverty and racism as the major mental health problems. This paper emphasizes the need, in the light of history and research, for consciously directed social change. Environment, it is contended, must be altered. New frames of mental health practices now rest on the interdependence of psychological and social matters. The paper concludes that reform has effected a new climate and, resultantly, some new institutional forms. It also questions whether the commitment to improve the quality of life and seek the objectives of social reform can be broadened into a national one. (TL)

ED 040428

American Orthopsychiatric Association
March 25, 1970
San Francisco, California

Norman Lourie
Daniel Walden

THE LESSONS OF HISTORICAL REFORM MOVEMENTS:

THE RACISM MENTAL HEALTH EQUATION

In the late 19th century, and in the early part of the 20th, reformers served as initiators and organizers of the social welfare functions of government and the voluntary sector at all levels. Optimists "who wanted to make a number of sharp changes because they believed in the rightness of things as they were," progressives with a vengeance, they were a new intellectual class championing the new radicalism of their time. Jane Addams, Lillian Wald, Walter Weyl, Herbert Croly, Walter Lippmann, Mary Richmond, Margaret Sanger, W. E. B. DuBois, Ida Tarbell, Randolph Bourne, Lincoln Steffens, and many others, were caught up by the issues they dealt with, by the ideals they articulated and struggled for. As intellectuals who were reformers they were driven people, impelled by compassionate motives and their forms of alienation, to be the movers and shakers in their society.

And there were issues. The depressions of 1873 and 1893 enriched the few at the expense of the many. Progress and poverty, to use Henry George's phrase, seemed a reality causally connected. The underclass suffered in the grip of what was said to be the inevitable economic determinism of a rapidly industrializing nation. Americans found themselves at the end of the 19th century fulfilling "our manifest destiny," extending

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

CG 005 432

"Passage to India," echoing Andrew Carnegie's sentiment that "All is well since all grows better;" whatever happened, as John D. Rockefeller put it, was not an evil tendency but "merely the working out of a law of nature and the law of God."

At the same time, as America flexed its muscles, racism and imperialism at home and abroad became part of what seemed a necessary flow of events for what were so-called "inferior" civilizations. Even as the new white immigrants from the Mediterranean and East European countries were arriving, they were greeted by anti-catholicism, anti-semitism and nativism. The Southern publisher, Henry Grady, declared apprehensively that "Those who put the Negro race in supremacy would work against infallible decree, for the white race can never submit to its domination, because the white race is the superior race." Moreover, in Thomas Nelson Page's words, "the Negroes, as a race, have never exhibited much capacity to advance, . . they are inferior to other races." Predictably, the Alabama Advertiser declared in 1903: "The white race has a duty which is imperative. It is a duty which is demanded by justice, by humanity, and by self-interest. Ours is and will ever be the governing race."

What appeared to some Americans as the province of nature, the way by which their God-given privileges was held, was seen in a different light by others. Racism, that curse hanging over America from its inception, had remained and enlarged even in a reform era. It surprises many that

that progressives - that is, urban middle class reform-minded white Americans - often used the rhetoric of the racist-imperialist. It was Theodore Roosevelt who said, in 1895, "A perfectly stupid race can never rise to a very high plane; the negro, for instance, has been kept down as much by intellectual development as anything else." And it was Woodrow Wilson who initiated segregation into the highest levels of the federal government and defended his stance with the explanation "that the friction, or rather the discontent and uneasiness, which had prevailed in many of the departments would thereby be removed."

At the same time, the humanitarian agencies were often spokesmen of a benevolent paternalistic gospel. Conscious of the European and national precedents of the desirability of investigation, coordination, and personal service, they considered the systematic implementation of such principles a genuine innovation. Charity organization spokesmen like Josephine Shaw Lowell of New York, Robert Treat Paine and Zilpha Smith of Boston, Mary Richmond and John M. Glenn of Baltimore, were missionaries in the most literal sense of a new benevolent gospel. They viewed themselves, as Roy Lubove has phrased it, as exponents of a holy cause, priests lighting a path to secular salvation: The New York Charity Organization Society warned that "if we do not furnish the poor with elevating influences, they will rule us by degrading ones." S. Humphreys Gurteen of Buffalo focused on "the wound of idleness and improvidence," and he suggested that "the indisposition to do manfully our appointed task in life" would lead directly "to poverty, destitution and want." Charity organization and volunteer visiting in particular were to many in the late 19th century the "only hope of civilization against the gathering curse of pauperism in great cities."

And it was Jane Addams, with her ardent faith in reform, in inevitable progress, who in 1909 saw a moral decline, a world sunk in a materialistic morass, without moral standards. Yet, she continued to work toward an ideal, "the slowly advancing race." Like Dr. Pangloss she believed that "The world grows better because people wish that it should and take the right steps to make it better." It was assumed that the social machinery could be manipulated to achieve a desired result. In her 1911 book, Twenty Years at Hull House, she held that "when the sense of justice seeks to express itself quite outside the regular channels of established government, it has set forth on a dangerous journey inevitably ending in disaster," in spite of the motives. All her efforts at Hull House were directed attempts "to socialize democracy," in the framework of a "social ethic," a sense of responsibility toward society. And all her efforts were palliative. Cures eluded her.

Meanwhile, paralleling the emergence of social diagnosis as a specialization, charity organizations and children's aid societies at the turn of the century were slowly moving toward investigation techniques and methods of diagnosis and treatment that would result in an understanding of the unique problems of each client. Scientific social diagnosis was slowly emerging as psychology, psychiatry and psychiatric social work, and school and medical social work arose. The old motto - "Not alms but a friend" - gave way to neither alms nor friend, but professional relationships, professional service, and superior expertise. Even a new kind of psychiatric link with social work was forged. The probability of multiple

causation in delinquency and dependency, and the need for comprehensive physical, mental, psychometric, and social examinations of deviant individuals - all of these in psychiatry - now paralleled the drift of social work towards differential casework. "In place of the passive descriptive psychiatry of the older tradition," said Adolph Meyer, "limited to 'insanity' and 'asylums,' and the mainly prognostic-dogmatic, diagnostic-nosological newer psychiatry of Kraepelen, concerned with classification rather than therapy, a biological, dynamic psychiatry which included the whole of human nature had arisen to pledge itself to research and teaching, based on an interest in daily work with patients." A clinical, empirical approach to mental illness was being substituted for the institutional isolation and custodianship of the 1890's. And, insofar as mental activity was now seen as the product of a "sufficiently organized living being in action," man was viewed as a social being, with a social environment.

Similarly, in the psychotherapy movement there was a formal recognition of the medical value of a constructive intellectual and emotional environment, especially in the treatment of what we would now call neurotic diseases. Basically the physicians involved ignored materialism and pessimism and tried to effect cures by whatever method worked. Thus, psychoneurotics were defined in 1909 "as people who, for one reason or another, are not well adapted to their environment." The conclusion follows, as one psychiatrist observed in 1911, that "if the mental habits and the surroundings of an individual are largely responsible for the onset of a psychosis, we can look forward to accomplishments which may rival the

success achieved in the crusade against tuberculosis." In other words, the most important feature of the psychotherapist's arsenal was to re-educate the patient to adapt to his environment, to adjust to the reality around him. At the same time, some physicians saw the possibility of altering not just the patient but also his environment. Social meliorism became the commitment for the most avant-garde of the Progressives. In a way psychiatry of that day tended to follow the lady bountiful notions of charity organization movement.

Paralleling this development, the ferment in psychological circles at first revolved about consciousness and introspective methods; in the first decade of this century study focused on the human organism in its environment, using the methods of animal psychology. The purpose of the revolt, as John B. Watson made clear in 1913 in behaviorist terms, was to make psychology into "a purely objective experimental branch of natural science." Thus, "Its theoretical goal is the prediction and control of behavior." Yet it must be remembered that the saying is not the doing. The optimistic social reformism of the American psychiatrists, psychologists, caseworkers, and settlement house workers, was after all an extension of Progressivism. And the Achilles heel of the Progressives was their inability to disassociate from racist and imperialist positions. In this reform-stance democracy and success depended on and were equated with the wisdom and guidance of the expert. In retrospect, lovers of mankind were all around but effective reformers, radical reformers, were still in short supply. At the same time then that the moral standards of the traditional sort motivated the social and political reformers, this generation, according to philosopher George

Santayana, was "in full career toward disintegration." In spite of the climate of progressivism, in spite of the humanitarian agencies and the work of those dedicated people known to us all, in the large sense "the Progressive movement passed over the Negro question and, ironically, by so doing, helped to promote the militant approach to the problem (then and now) that most progressives would have abhorred."

In this context W. E. B. DuBois predicted at the turn of the century that the problem of the 20th century would be the problem of the color line. Believing in the inevitability of progress, he held that "The world was thinking wrong about race, because it did not know," and the cure was "knowledge based on scientific investigation." Only a few years later, at the height of Theodore Roosevelt's reformism, DuBois proclaimed that "We will not be satisfied to take one job or title less than our full manhood rights. We claim for ourselves every single right that belongs to a freeborn American, political, civil, and social; and until we get these rights we will never cease to protest and assail the ears of America." That early black man who wore the mask that grinned and lied, to paraphrase Paul Lawrence Dunbar, was stirring. Even then the ethnic conclaves were forming and the suburban movement swelling as the spatial segregation of the so-called less "dangerous classes" fed the suburbanization. The religious spirit of American reform so prevalent before the Civil War was being perpetuated into the 20th century. Indeed, one must wonder, looking at the ever-changing process that is culture, why the pattern of Negro aggressive

behavior then was so limited, why adaptation (usually pictured in the ideals and practice of Booker T. Washington) prevailed in the face of such overt oppression. The answer seems to be that much aggression was directed against a surrogate, (that is, a colored object for the white object of aggression), or to an ivory tower retreat, or into an identification with the whites concerned. (Indeed) Until recently direct aggression against the true object, the oppressor, was rarely used. For the cultural process involved not only a denial of privileges but a promise of penalty, or compensation - ie., future blessings in heaven, material security, foiling the whites, feeling more virtuous than the whites. Unfortunately, most blacks then opted for adaptation, for adjustment. Not surprisingly, in view of the widespread attitude of white reformers that the presence of Negroes in a white neighborhood would drive whites away. As one Boston spokesman explained, "White people would keep away from any place except a church where it was known that colored people resorted." Or as an unenlightened settlement worker put it: "Our settlement has its unique problem for it deals not with a race that is intellectually hungry, but with a race at the sensation stage of its evolution and the treatment demanded is different." (Our italics.)

Yet, interestingly, the remarkable fact about the Progeessive period is that there were few social tensions. Compared with the earlier Gilded Age or with the 1920's and 1930's, it was a period of social peace. Not competition but cooperation distinguished the era. But it must also be noted that it was the depressions of 1873 and 1893 that radically alerted the previous complacency of the Gilded Age. As Thorstein Veblen observed, in

1894, large numbers of Americans no longer believed in the gospel of self-help, no longer could be assured by a general prosperity -- which had vanished -- that industrialism might cure its own ills. The depression-inspired search for answers and proposals had become more important than a man's social origins. The social unrest accompanying the depression-inspired search for answers and proposals had become more important than a man's social origins. The social unrest accompanying the depression weakened class and status allegiances. The programs that were now generated stressed tax reform and corporation reform; and the issues cut across class lines. In short, the basic problem for the reformer in the progressive era, in a time when cooperation reigned, was how to win mass support. The basic riddle thus was not what drove men apart but what made them seek common cause, and why blacks were forgotten in the depression of the 1930's and the surge of social law and development in its wake set the stage for the radical reformers, white, black and professional who emerged in the 1960's. The mental health and social welfare movement were stirring since the 1930's but were not the leaders of the new reform. Mental health leaders like Erich Fromm and the young university psychiatry field emphasized the interdependence of environment and mental disturbance. Literature on mental health and social class was popular. But there were no fundamental changes in practice until the civil rights revolution gained full momentum in the 1960's and such concepts as maximum participation of the poor, black power, neighborhood control, and a wide range of confrontation techniques

shook the helping fields and sent academicians and practitioners to, as the vernacular has it, put their money where their mouth was.

This audience knows the recent history - the Supreme Court decisions, the painful process of desegregating schools and colleges, the trade union problems, the urban disturbances, black dignity, black separatism, black power, Mexican American, Puerto Rican American and American Indian freedom movements, new careers developments and the opening of the social and mental health agencies to non-professionals. And we all know the backlash that still remains and we have been sharply made aware of the silent minority.

In the spring of 1968 the Committee on Minority Group Children, of the Joint Commission on Mental Health of Children, concluded that racism was the number one public health problem. Knowing that this problem was interwoven with socio-economic factors, the Committee stressed that a high priority must be given to the elimination of poverty and racial discrimination, that the accent must be on prizing cultural diversity and promoting communication between population segments, and that opportunities must be provided youth for constructive involvement in society. The Joint Commission's final report echoes these thoughts.

That summer at the 14th International Conference on Social Welfare, in Helsinki, Finland, human rights was the topic. The "elimination of racial discrimination" was again an unhappy subject. Similarly, during the National Conference on Violence in Our Time (September 1968) it was stated clearly that "poverty <u>is</u> violence -- violence against people .... It, with racism and war, is our major mental health problem." The logic (or

facts more) was indisputable: "Poverty and racism are our major mental health problems. Poverty brings frustration. Frustration brings anger. Hate is a partner of anger. Anger brings violence. Frustration depends as much on one's frustration tolerance as it does on external stimuli and as standards of living and aspirations rose, frustration levels went down. What was enough in 1800 America is misery for the poor of today, with their painful awareness of the non-poor sharpened by the mass media."

But the same words could have been said for the 1890's and the 1930's. The difference is that millions now suspect the universality of what was called the American Dream, and many more see the inequality, and for the first time the poor themselves -- the blacks, the Puerto Ricans, the Mexican Americans, the Indians, and the whites - have now joined the fray.

Some of our cherished economic ideas were fashioned for a world now obsolete. Our complacent concept of poverty, seen in past decades as caused by intemperance, extravagance, improvidence and indolence, are giving way to facts. The belief that the power of economic growth would solve our problems is another fantasy that is being given up grudgingly. In our narrow charity philosophy we saw assistance to the poor as benefits, not rights. Through our-makeshift systems we too often usurped rights to individual dignity, equality and effective freedom. Our vaunted money transfer systems all alleviated but failed to cure poverty. The weakness of the poor over the decades allows the political system to discriminate against them. The poverty program (the continuing "skirmish" in place of a war) has not appeared to really challenge the power of the political and

economic policy managers. As always, the commitment to principle is needed. In view of the fact that our social welfare outlays per capita, excluding those for education, have been virtually at a standstill since 1961, the prospect seems grim. But there is hope. Cry for a new sense of national commitment to human service is widespread. Polls, like Gallup's reveal that a large percentage of Americans accepted the guaranteed minimum income idea. And while we reject the idea, we really do have many attributes of a welfare state.

Some of the objectives that must be attained are before us. A guaranteed income that is related to cost of living is one. At the same time, to prevent income maintenance from becoming a perpetual minimum or a demeaning vise, comprehensive democratic planning through new national, regional, metropolitan and neighborhood structures must be employed. Our business-oriented work ethic, our work-equals-personal worth doctrine, are still at the end of the road. To hold on to the work incentive and make it stick in the face of a guaranteed income is part of the problem.

But treatment programs for children and youth must also be updated. Though we know more in 1970 the knowledge-practice gap has not substantially altered. Our arrangements for service delivery unfortunately seem geared more for professionals and field needs than to the needs of children. We deal with crises more often than with prevention: We serve only a fraction of the need population: We start too late. We do not construct programs to follow our research findings. Indeed it must be admitted that "There is no universally accepted scientific definition of mental illness," and "There is no mental health science as such." Thus, as the Joint Commission

recommended, the total child care system must be reordered. If we really want to develop a national commitment to children and to implement it in every neighborhood and for every family, we have to think in the social utility sense and not be afraid of the consequences.

Beneficence has been the basis of America's social welfare system. Our customary attitude, derived from a philosophical tradition strongly influenced by Social Darwinist concepts, has emphasized individual responsibility. The American gospel of success is the more active form of this phenomenon; indeed a kind of social and economic anarchic individualism has reigned. The need for consciously directed social change has not been part of America's approach to social welfare, Rather than utilize planning - so antithetical to those who can speak only of laissez-faire - this country has tended to react to situations only after they have developed. Pragmatism and improvisation have characterized our way. As a result, as the Kerner Commission and as the Commission on Violence have pointed out, fundamental change in America has come only through violence, through bodies "out in the streets." The point was made at the same time that our society since the 1930's has been more and more willing to work outside the market system for social welfare than ever before.

True, as President Nixon stated in his August 11, 1969, message to Congress, "the present welfare system has failed us." It seems to have fostered family breakup, provided very little help in many states, and even deepened dependency by all too often making it more attractive to go on welfare than to go to work. Meanwhile, it is proposed that the Family Assistance Plan

would replace Aid for Dependent Children, and provide a federal income floor for all families with children, regardless of work status. Needless to say, some negative factors must also be considered. The proposal is static in that it reflects no progressive movement toward an adequate level of income. It makes no provision for cost of living changes. It makes no provision for single adults and childless couples under 65 who are poor and not disabled, Moreover, though the FAP would reach about 22. 5 million low income families, some 10% of the population, it is estimated that 56. 4% would go to whites while only 43. 6% would go to non-whites.

Of course, the recent proposals can be described as forward thrusts. Nonetheless, the prospect remains alarming. Unemployment rates for non-whites and females are still twice that of whites and males. Nearly half of all non-white families earned under $3,000 in 1966, while about 1/5 of the white families were in this category. In sum, as the Commission on Civi l Disorders stated, our society seems to be moving toward "a kind of urban apartheid with semi-martial law in many major cities, enforced residence of Negroes in segregated areas, and a drastic reduction in personal freedom for all Americans, particularly Negroes." One year later, Urban America Inc., and the Urban Coalition, cautioned "We are a year closer to being two societies, black and white, increasingly separate and scarcely less unequal."

Certainly the federal legislation enacted in the last decade exemplifies a new sense of dedication to the national avowal that all citizens enjoy equal opportunities. But, simply put, all of this activity has not been effective

enough; the mounting pressure for change demands original and ever-greater responses to the new needs and circumstances. Black leadership, self-determination, and power needed to unite the community are as much mental health necessities as a guaranteed job and a guaranteed income. The civil rights movement, clearly-non-violent, has given way to a strategy of confrontation, including sophisticated use of legal and psychological devices -- the courts, sensitivity training, use of social agencies as a base of operation, etc. In social welfare, the welfare rights movement has become a significant force working toward acceptance of the concept of public assistance as a right not a charity, toward more adequate grants and eligibility based on need, toward greater responsiveness on the part of systems that formerly fostered paternalism and dependency.

Almost axiomatically, the awakening to racism and the "discovery" of poverty have been the impelling forces. The knowledge that a gap exists and has persisted between the American credo and practice has been an added push. As President Kennedy put it in 1963, "Poverty in the midst of plenty is a paradox that must not go unchallenged in this country." Five years later the Kerner Commission said forcibly that "America must be prepared to spend billions to wipe out ghettoes, provide jobs, schools and housing for the American minorities trapped in helpless poverty--or face the destruction of our democratic society."

The past teaches that from a stance of do-goodism the mental health and social welfare community has progressed through prescriptive adaptation to social meliorism and, recently, to an awareness that not just the

patient but the environment must be altered. It has become abundantly clear that racism is a cancer inside our body politic. Few now doubt that any significant structural change must be grounded on a racially aware consensus. Scientific investigation, the American ideal, and the uncertainty that men must seek common cause this time, convince one that if these criteria are honored our number one public health problem will be diminished to the point of obscurity. As in the past, however, the question of how to win mass support for changes that will alter the structure of privilege inherent in our social system is a thorny one. The element of privilege, as Robert Heilbroner has shown, is usually passed over in favor of the purely functional aspects of our institutions; private property, for instance, is ordinarily explained as being no more than a convenient instrument for the efficient operation of an economic system; or the market elements of Land, Labor, and Capital as purely neutral "factors of production." There are other points of view. The fact is that the operation of our system as a functional system results in a structure of wealth and income which comes out as a system of privilege. We temper this with what are euphemistically called welfare state measures - ones which do not upset the system but which allow it to function within the broadest parameters possible - while saving it from itself.

In the end, one must deal not only with the maldistribution of income and the social problems that spring from it, but the economic malfunction that has racked our society for more than a hundred years and that vibrates to the desires and attitudes of men. Against these forces can be marshalled the explosion of organized knowledge and scientific technology. Just as old ideas and practices have historically given way to better ones, so now an imperceptible transfer of

of privileges is taking place. Hopefully the process seeking cultivation and enrichment of all will be effected non-violently.

Current developments in mental health and social welfare show that we have gone the complete circle at least ideologically. A major question is whether we can tie the knots.

The conclusion and recommendations of the Joint Commission on the Mental Health of Children in many ways mirror the recommendations of the Commission on Violence, and Civil Disorders, on Crime and Delinquency and others which looked at specific social phenomena. Poverty and racism turn up as the major American mental health and social problems and their elimination gets high priority.

The new frames of mental health practice, community mental and community psychiatry rest on the interdependence of psychological and social matters. We appear to be convinced that solution of the individual's mental problems are inextricably woven in the frame of reference of the community's problems and vice versa.

While there is no precise agreement on what should be the scope of community mental health, it is clear that it is not a one-field matter, simple to define and isolate.

The literature on community mental health programs are virtually texts on the complete range of health, mental health and social welfare services. In this document we do not go into relative effectiveness of delivery systems or the problems of coordination or issues of auspice, centralization, decentralization, virtues of entrepreneurial versus social utility approaches, etc., all of which are major matters involving technique rather than substance. In passing we only say that the multitude of guilds and interests engaged in

delivering human services appear to concur more on substance than on procedure and technique. The danger is that we may, once again, achieve a triumph of technique over purpose as the professionals, bureaucrats, and citizen and political interests struggle over who should control which delivery system. In our pluralistic society where goal achievement often rests on issues of control and coordination, these are important matters which cry for solution.

The important fact is that the reformers of the 1960's, the citizens affected, including the poor, as well as the professionals, seem to have arrived at some fairly common understandings. We appear to agree that the search for the sociococcus is equally as important as the search for the schizococcus and in fact accept their interdependence. We appear to agree that poverty and racism must go and that our service delivery is not a benificent "doing for" but a genuine serving of and working for the people on truly human services in which our expertise serves but does not control people.

The community mental health center model begins to include the widest range of social welfare, social action reform models. No respectable mental health center rests solely these days on clinical treatment. In fact many mental health centers are having some uncomfortable moments as their so called "disadvantaged" clients (the settlement houses used to call them neighbors) and new careerists on staff, emphasize the irrelevancies in some clinical model activities and press for more social action.

In some respects we cannot distinguish some activity of the mental health center from the settlement house, The agency concerned with social action in a specific field, housing for instance, the community action program, and so many other traditional and new social welfare agencies. In respect to the specific issue of racism many mental health centers are engaged, apart from their clinical concerns, in a range of activities which might help minorities achieve individual and group status and power, improve social conditions and reshape the environment positively.

It is only fair to note that the insights and concepts underlying these recent institutional function shifts are not entirely new in the mental health and social welfare fields. The literature of the American Orthopsychiatric Association or the group for Advancement of Psychiatry and some branches of our several professional societies reveal that Presidential messages, congressional actions, professional, bureaucratic and citizen agency actions are catching up with ideas once considered far out or radical. Young people in our professions do a double take when we quip that the social welfare and mental health movements, among others, were squeezed between Freud and Joe McCarthy. Those of us who lived through the excitement of the 1930s and the relative suppression of the 1940's and 1950's may squirm uncomfortably at the memories, but they are nevertheless real and at the least, disconcerting.

Modern reform has, in effect, created a new climate, some new institutional forms and what appears to be a wider commitment to improve the quality of life and to more firmly seek the objectives of social reform and

social justice; to make real the concept of the right to life.

The question is whether we can make the commitment as a national one and develop the resources to pull it off.

Without question, what is needed is a combination of national and community action to generate the national reforms necessary to meet national crisis. Our highest national leaders have agreed that crisis is inherent in racism, poverty and outmoded delivery systems. Translated into reality this means direct attacks at all levels to achieve a guaranteed minimum income, to eliminate all vestiges of discrimination, to wipe out malnutrition, meet manpower shortages, create logical access to facilities and to eliminate all barriers to well-being created by unhealthy environments. These are ecological concerns in the broadest and most specific sense. They are far from being only mental health or social welfare concerns alone.

Orthopsychiatry and ecology share an affinity. American dictionaries define orthopsychiatry as prophylactic psychiatry concerned especially with incipient mental and behavior disorders. Ecology is defined as a science concerned with the totality or pattern of relations between organisms and their environment.

Ecology, while not yet a household term, is becoming widely used. We have not yet heard of a student group becoming concerned with ortho-psychiatry or community mental health as a major cause. Concern with ecology has been loudly expressed as a major cause for both student groups and urban coalition advocates.

We are not suggesting orthoecology as a term for a field or an

organization. But as we search for ways to characterize the present state of reforms, we look forward to the potential alliances of the mental health and social welfare reformers with ecologists, in our joint efforts to clean up the physical, social and biological.

Perhaps mental health ecology may be a useful notion to play on. Certainly examination of common goals is a useful direction.

Having come this far, espousing economic and social goals, including elimination of poverty and racism, as important mental health objectives, we must use the lessons of history to avoid slippage.

The history of reform is characterized, in part, by professionals, guilds and agencies succumbing to the tempatation to put professional and guild self-interest above the public interest. In the general health field, for instance, this led to the present crisis which even the most conservative find hard to deny.

The best defense against such narrowing of vision is to keep as close as we can to the people we serve, to make certain that they are allied with us in our designs and in our translations and that we share the action with them.

In our system, the battles are ultimately joined in the political arena. We seem to have learned that lesson and the urgency is to become expert at it and then not forsake it no matter how tough the going gets.

There is still a long way to go. There are still many battles to be fought. Let us meet them head on.